DEPARTMENT OF HEALTH AND HU... ...N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 02/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445388	A. BUILDING _____ B. WING _____	02/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS CENTER OF SPENCER	87 GENERATIONS DRIVE SPENCER, TN 38585

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).	F 285	The facility failed to ensure a complete medical record including a PASRR had been completed for two (#6,#7) of eighteen residents reviewed. PAE nurse/L.P.N. submitted for an updated PASRR on 02-10-11 to the State of Tennessee for resident #6. PAE nurse/ L.P.N. contacted the State of Tennessee for copy of resident #7 PASRR on 02-09-11. A copy of the PASRR was faxed on 02-11-11. The copy was placed on resident #7 chart on 02-11-11 by PAE nurse/ L.P.N. The quality assurance nurse/ L.P.N., PAE nurse/ L.P.N. and Assistant Director of Nursing/ L.P.N. reviewed 100% of active resident records on 02-10-11 and 02-11-11 to ensure all records have PASRR in active file. PAE nurse/ L.P.N. will ensure all active records have a PASRR on file on admission and readmission. The quality assurance nurse/ L.P.N. will review all new admissions and readmissions for PASRRs for three (3) months and then 10% of all active files annually for one (1) year to ensure compliance.	02-11-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 2-21-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 285	Continued From page 1 (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to ensure a complete medical record including a PASSAR (Preadmission Screening and Annual Resident Review) had been completed for two (#6, #7) of eighteen residents reviewed. The findings included: Resident #6 was re-admitted to the facility on May 14, 2010, with diagnoses including Paranoid Schizophrenia, Obsessive Compulsive Disorder, and Agitation. Medical record review of resident #6's current chart and the resident's overflow chart in the medical records office failed to reveal that a PASSAR had been completed(PASSARs assess mentally ill resident's to ensure appropriate services are provided). Resident #7 was admitted to the facility on December 14, 2007, with diagnoses including Closed Head Injury, Vascular Dementia, Anxiety, and Impulse Control Disorder. Medical record review of resident #7's current chart and the resident's overflow chart in the medical records office, failed to reveal that a PASSAR had been completed.	F 285		

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F 285	Continued From page 2 Interview on February 9, 2011, at 11:45 a.m., in the conference room with Licensed Practical Nurse (LPN) #1 (responsible for ensuring PASSAR's are completed) confirmed there was no evidence in the medical record that the PASSAR assessments had been completed.	F 285		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the pharmacy provided the correct medication for the emergency box of antibiotics as labeled, that medications and intravenous solutions were within the expiration dates; and that medications requiring refrigeration	F 425	The facility failed to ensure the pharmacy provided the correct medication for the emergency box of antibiotics as labeled, that medications and intravenous solutions were within the expiration dates, and that medications requiring refrigeration were not stored with items deemed for consumption by the residents. On 02-09-11 all outdated medication and intravenous solutions were removed by director of nursing/R.N. and returned to Middle Tennessee Pharmacy. On 02-09-11 Middle Tennessee Pharmacy was contacted by director of nursing/ R.N. for replacement emergency medication box and intravenous solutions. Both were delivered on 02-09-11. The director of nursing/ R.N. checked the emergency box and intravenous solutions on 02-10-11 to ensure correct dosages, medications, and expiration dates. The staff nurse/ L.P.N. witnessed check. The pharmacy consultant/ PhD will check the emergency box and intravenous solutions randomly to ensure proper dosage, medications cont. to next page:	02-23-11

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F 425	Continued From page 3 were not stored with items deemed for consumption by the residents. The findings included: Observation of the emergency medication box for antibiotics with the Director of Nursing (DON) in the medication room on February 9, 2011, at 10:25 a.m., revealed three capsules of amoxicillin 500 mg (milligrams) had been placed in the compartment labeled "AMOX/CLA," a different medication (A combination drug of amoxicillin and clavulanate potassium). Observation with the DON on February 9, 2011, at 10:25 a.m., revealed the reconciliation of medications for the emergency antibiotic box revealed three extra capsules of amoxicillin 500 mg and no amoxicillin/clavulanate potassium. Continued observation revealed one capsule of cephalexin 250 mg (an anti-infective medication) had an expiration date of January 2011. Continued observation of the emergency intravenous (IV) fluid supply revealed one, 1000 ml (milliliter) bag of 5% Dextrose with an expiration date of September 2010, and one, 100 ml bag of 0.9% Normal Saline, opened. Continued observation of the refrigerated medications revealed eight cartons of dietary supplement and four cans of juice stored with the medication. Interview with the Director of Nursing (DON) on February 9, 2011, at 10:45 a.m., confirmed the medication placed in the compartment labeled "AMOX/CLAV" was not the correct medication,	F 425	cont. from previous page: and dates and report findings to the director of nursing/ R.N. The quality assurance nurse/ L.P.N. will verify the contents of the emergency box and intravenous solutions monthly for ninety (90) days and then twice annually for one (1) year and report findings to the director of nursing, R.N. On 02-09-11 all juices were removed from the refrigerator in medication room. On 02-23-11 all nurses will receive training on medication storage, infection control and a guide for storage policies by the director of nursing/ R.N. The quality assurance nurse/ L.P.N. will conduct random checks on the medication room refrigerator for the next ninety (90) days to ensure compliance and report findings to the quality assurance committee.	02-23-11

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F 425	Continued From page 4 the one capsule of cephalexin 250 mg had expired and should not have been in the emergency medication box, the expired and opened IV fluid should have been removed from the emergency IV fluid box, and the juice should not have been stored with medication. Interview with the Pharmacy Manager via telephone on February 9, 2011, at 11:10 a.m., confirmed, "...We may have filled the box incorrectly...If the medication box had extra amoxicillin, then the only thing that makes sense is that we put the wrong medication in the box..."	F 425		